May 7, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013, Baltimore, MD 21244–8013
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Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for Stage 2 of the Meaningful Use Incentive Program.

Health information technology (HIT) is a powerful tool for advancing high-quality, patient-centered care—that is why we closely aligned the Patient-Centered Medical Home (PCMH) Recognition program with Meaningful Use. Our PCMH program is by far the most widely used road map for transforming primary care into high-value, patient-centered care. There is a great deal of synergy between the Meaningful Use and PCMH programs, which share many functional objectives. Importantly, we can provide a summary file to CMS listing clinicians in NCQA-Recognized PCMH practices who are "meaningful users" of HIT.

We also are stewards of the HEDIS® (Health Care Effectiveness Data and Information Set) measures, which are commonly used by health plans and providers to gauge care quality and efficiency. With support from CMS, many HEDIS® measures have been re-specified for electronic reporting. Electronic health records (EHRs) present an opportunity to develop and implement new measures supported by the enhanced access to clinical data.

Moving in the Right Direction. We support the proposed Stage 2 meaningful use criteria that increase expectations for eligible providers and hospitals by building on existing requirements or by adding new requirements. This is important to encourage providers to make gains over time and the wise use of taxpayer dollars. In addition, proposed Stage 2 criteria:

- Maintain flexibility for eligible providers and hospitals by including both core and (optional) menu criteria.
- Allow clinicians to report clinical quality measures and attest to meeting core and menu objectives as a group.

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- Align with existing CMS programs, such as the Physician Quality Reporting System (PQRS) and the Shared Savings Program.
- Emphasize patient-centered care by requiring providers to use electronic methods of communication with patients.

Collectively, these steps and others will help the Meaningful Use Program continue to grow with Stage 2 in 2014.

NCQA's PCMH Recognition Program. As of March 2012, NCQA has recognized more than 20,000 clinicians (in roughly 4,100 practices) as medical homes. Over 25 states have private and/or public payers providing incentives and or technical assistance to practitioners pursuing NCQA PCMH Recognition. The program is growing rapidly because it helps turn primary care into what patients want it to be. That means:

- Patients have long-term partnerships with clinicians and enhanced access during and after office hours and through online communication, instead of a series of sporadic, hurried visits.
- Patients collaborate in their care, which makes care more patient-centered and sensitive to culture and language, and care is based on shared decisions so patients make more informed choices and get better results.
- Clinician-led teams coordinate care, with an emphasis on prevention and managing chronic conditions across settings, including specialty clinicians', facilities such as hospitals and emergency departments, and community supports, as needed.

The program has also resonated with clinicians tired of working in a high-stress, financially challenging and fragmented delivery system. Becoming a PCMH enables clinicians to provide care the way they would like to, and research indicates lowered clinician burnout following medical home transformation.[1]

PCMH Recognition and Alignment with Meaningful Use. Electronic medical records, clinical decision support tools and other technologies can help practitioners track patients with chronic illness, proactively reach out with preventive care reminders, safely prescribe medications and effectively communicate with patients and other providers. In short, HIT supports full medical home transformation. That is why NCQA updated our PCMH program to closely align with Meaningful Use in 2011.

[1] Reid et. al, The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. *Health Affairs, 29, no. 5 (2010): 835-843*

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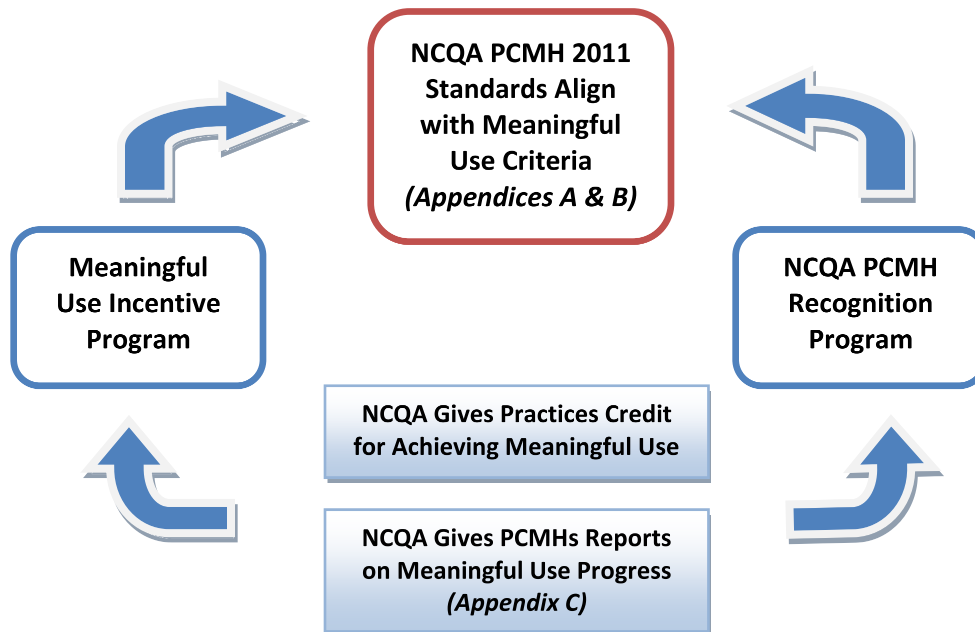
Figure 1: NCQA PCMH Alignment With Meaningful Use



A high-level, one-page crosswalk of how PCMH standards match up with Meaningful Use objectives is available in *Appendix A*. A detailed crosswalk of PCMH standards and specific Stage 1 and Stage 2 criteria is in *Appendix B.* Both documents show how NCQA PCMH 2011 Recognized practices are well on their way to meeting Meaningful Use requirements and vice-versa. For example, NCQA PCMH standards and Meaningful Use criteria overlap in areas of electronic prescribing (eRX), recording demographics and medication reconciliation, among many others.

NCQA's process to recognize practices as PCMHs also aligns with Meaningful Use. If more than 75 percent of a practice's clinicians have achieved Meaningful Use, the practice can receive credit on the applicable PCMH standards, reducing reporting burden and encouraging those practices receiving incentive payments to work towards becoming a medical home.

Recognized PCMHs also receive performance reports identifying the corresponding Meaningful Use requirements they have met. These reports help PCMHs that have not yet achieved Meaningful Use to focus their HIT implementation efforts. Refer to *Appendix C* for a sample report.

NCQA can also provide CMS with a comprehensive file containing the names and national provider identifiers of clinicians in recognized PCMHs that meet Meaningful Use criteria. In the future, CMS could use this file to give clinicians in recognized PCMHs automatic credit for the corresponding Meaningful Use objectives. This would reduce reporting burden on both

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regulators and clinicians and encourage more clinicians to seek PCMH recognition and Meaningful Use incentive payments.

We are committed to preserving the alignment with Meaningful Use and will update the PCMH standards once Stage 2 requirements are final.

Recognition by Practice vs. Clinician NCQA's PCMH program evaluates entire practices, not individual clinicians, because high-quality, patient-centered care requires efforts of a well-coordinated team. Providers, even those in solo practices, do not deliver all care by themselves; they work in teams that include both clinical and non-clinical staff. So, while the actions of an individual clinician are important, it is critical to look at the group when gauging performance.

The team concept also applies to use of HIT. For example, EHRs and other technologies are typically implemented at the practice level, not by an individual clinician within a larger practice.

NCQA supports the proposed Group Reporting Option of Core and Menu Objectives, where providers in group practices would be able to attest to Meaningful Use requirements using a "batch file process." This will reduce administrative burden and is a step toward the ultimate goal of evaluating performance at the practice level.

However, providers still must attest to meeting Meaningful Use requirements on an individual basis, even under the proposed group reporting option. This limits the ability to take advantage of the alignment between the PCMH recognition program—which is specific to practices—and Meaningful Use. We strongly encourage CMS to work with Congress, the HIT Policy Committee and other stakeholders to allow providers at recognized PCMHs to satisfy the corresponding Meaningful Use criteria. This would reduce burden on both providers and regulators and encourage eligible providers in PCMHs to seek Meaningful Use incentive payments.

Standardize Clinical Quality Measure (CQM) Reporting Across CMS Programs. The proposed rule gives eligible providers (EPs) multiple pathways (including the option of reporting to PQRS) to fulfill the Stage 2 CQM reporting requirement. The flexibility for EPs and alignment with other CMS programs are strong steps forward.

CMS can further the alignment by standardizing physician CQM reporting methodologies across its programs. Under PQRS, physicians are required to report quality measures based on their Medicare population only; under Meaningful Use, physicians report on their entire panel of patients. This could complicate the process of combining CQM data and benchmarking physician performance. In addition, NCQA does not believe that providers change their practice based on payer and including all patients will only increase the accuracy of CMS' quality reporting efforts. We urge CMS to update the PQRS methodology and allow physicians to report based on their entire panel of patients.

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Specialty Practice Recognition. NCQA is developing a recognition program for specialists that effectively coordinate with other caregivers. It will be similar to our PCMH program—where providers are evaluated on their ability to meet a set of consensus-based standards. However, it will focus more specifically on how specialists work with primary care providers to effectively care for patients.

Research shows that patients can fall through the cracks when specialists do not communicate. For example, a recent study showed that primary care practitioners report *sending* information to specialists 70 percent of the time, while specialists report *receiving* that information only 30 percent of the time. The same study found that specialists report *sending* information to primary care providers 81 percent of the time, but primary care providers report *receiving* that information only 62 percent of the time.[2]

Adopting HIT can help practitioners share information, such as summaries of a visit and lab data, more efficiently. As with our PCMH program, we plan to closely align the specialist recognition program standards with Meaningful Use criteria.

Clinical Quality Measures (CQMs) and PCMH Recognition: Technical Corrections. Clinicians seeking PCMH recognition receive credit for fulfilling Meaningful Use Stage 1 CQM reporting requirements.[3] They can also get credit for setting performance goals and acting to improve performance on measures in certain categories—prevention, chronic disease or acute care, and utilization. [4] However***,*** these are not "must pass" elements required to obtain recognition.

We therefore recommend CMS remove references to NCQA PCMH Recognition in Table 8, starting on page 13749 of the Federal Register, Vol. 77, No. 45. Instead, we encourage CMS to add preamble language describing the PCMH program's CQM reporting standards. We would be happy to work with CMS on this language.

CQMs and Physician HEDIS®: Technical Corrections. We are pleased that CMS referenced HEDIS® in Table 8 under the column "other quality measure programs that use the same measure." However, some measures in Table 8 are inaccurately labeled. To ensure measures are correctly attributed to NCQA programs in the final rule, the crosswalk in *Appendix D* identifies which CQMs proposed for eligible providers are also in Physician HEDIS®.

CQMs and NCQA's Diabetes Recognition Program (DRP) and Heart Stroke Recognition Program (HSRP). NCQA has programs separate from PCMH that recognize clinicians who demonstrate delivery of high-quality care for patients with diabetes and cardiovascular disease (or who have had a stroke). To be recognized, providers must submit data—and meet

[2] O'Malley, A.S., Reschovsky, J.D. (2011) Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground. Arch Intern Med, 171 (1), 56-65.
[3] PCMH Standards, Element 6F
[4] PCMH Standards, Elements 6A-6C

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performance thresholds—on specific evidence-based CQMs shown to improve care. Currently over 14,000 clinicians are recognized in these programs.

Many of these CQMs are found in CMS programs and NCQA has been designated as a qualified registry for PQRS, reporting the ischemic vascular disease (IVD) measures group and the diabetes measures group. There is also alignment with measures proposed for Meaningful Use Stage 2, and we encourage CMS to add NCQA's DRP and HSRP programs to the column "other quality measure programs that use the same measure" in Table 8. Refer to *Appendix* D for a list of measures shared by the programs.

Please contact Sarah Thomas, Vice President of Public Policy and Communications, at Thomas@ncqa.org or at (202) 955-1705 with any questions.

Sincerely,

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President

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Appendix A: Health IT Meaningful Use & NCQA Patient-Centered Medical Home Alignment

MU-only	MU-PCMH Alignment	PCMH-only
	Protecting Privacy Protect EHRs/secure electronic messaging	
Family History *as structured data* (Stage 2)	**Using Patient Information** Record and chart vital signs Record smoking status Imaging results/ info accessible through EHR Clinical lab-test results in EHR as structured data Generate lists of patients by conditions Surveillance data to public health agencies	Comprehensive Health Assessment (including family history) Use Data for Population Management Plan and Manage Care Identify High-Risk Patients Care Management Measure Patient/Family Experience
	Patient Education/Self Care Clinical summaries to patients for each visit Let patients view online, download, transmit health information w/in 4 business days ID patients for preventive/follow-up reminders Use EHR to ID/provide patient-specific education	Support self-management/behavior change
	Care Coordination Summary record for each transition or referral Med reconciliation from other provider/setting	Care teams coordinate care Population management Support self-mgmt/behavior change Referrals to Community Resources Referral tracking & follow-up Performance evaluation & QI
	Medication Management Electronic Rx & CPOE for meds, lab & radiology	
	Decision Support Use clinical decision support to improve performance on high-priority health condition	
	Disparities Record demographics as structured data	Assess patients; racial/ethnic diversity Assess language needs Provide interpretation/bilingual services P printed materials patients' languages
Report to Registries (Stage 2)	**Reporting** Report clinical quality measures to CMS Electronic data to immunization registries	Measure and Improve Performance
	Enhance Access and Continuity	Same day appointments Phone/electronic advice After-hours access

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Appendix B: Crosswalk of Stage 1 and Stage 2 Meaningful Use Requirements and NCQA's PCMH Recognition Program

Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
1. Use CPOE (computerized physician order entry) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. More than **30 percent** of patients with at least one medication in their medication list has at least one medication ordered through CPOE (except for Any EP who writes fewer than 100 prescriptions during the EHR reporting period).	**1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.** More than **60 percent** of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	**PCMH 3E** 1. Enters electronic medication orders into the medical record for more than **30 percent** of patients with at least one medication in their medication list	PCMH 3E is consistent with the meaningful use (MU) stage 1 requirement. Stage 2 requires recording radiology and laboratory orders using CPOE in addition to medication and it also increases the requirement to **60 percent** from **30 percent**.

[5] Stage 1and 2 core requirements

[6] Stage 1requiements: https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

[7] Stage 2 proposed rule: http://www.modernhealthcare.com/Assets/pdf/CH78295223.PDF

[8] Analysis indicates changes made to stage 1 as well as differences between PCMH 211 and stage 2 requirements.

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
4. Generate and transmit permissible prescriptions electronically (eRx) More than **40 percent** of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology (may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology; excludes any EP who writes fewer than 100 prescriptions during the reporting period).	**2. Generate and transmit permissible prescriptions electronically (eRx).** More than **65 percent** of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.	**PCMH 3E** 4. Generates and transmits at least **40 percent** of eligible prescriptions to pharmacies	PCMH 3E is consistent with the stage 1 requirement. Stage 2 increases the requirement to 60 percent from 40 percent. Additionally, both stage 1 and 2 require use of **Certified EHR Technology.**
7. Record all of the following demographics • **Preferred language** • **Gender** • **Race** • **Ethnicity** • **Date of birth** **More than 50 percent** of all unique patients seen by the EP have demographics recorded as structured data	**3. Record the following demographics** • **Preferred language** • **Gender** • **Race** • **Ethnicity** • **Date of birth** **More than 80 percent** of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	**PCMH 2A** The practice uses an electronic system that records the following as structured (searchable) data for **more than 50 percent** of its patients. 1. Date of birth 2. Gender 3. Race 4. Ethnicity 5. Preferred language	PCMH 2A is consistent with the stage 1 requirement. Stage 2 increases the requirement from **more than 50 percent** to **more than 80 percent**.
8. Record and chart changes in the following vital signs • **Height** • **Weight**	**4. Record and chart changes in vital signs:** • **Height/length** • **Weight** • **Blood pressure (age 3 and over)** • **Calculate and display BMI**	**PCMH 2B** The practice uses an electronic system to record the following as structured (searchable)	PCMH 2B is consistent with the stage 1 requirement. Stage 2 increases the requirement from **more than 50 percent** to **more than 80**

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
• **Blood pressure** • **Calculate and display: BMI** • **Plot and display growth charts for children 2–20 years, including BMI**. More than 50 percent of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data.(may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology; excludes any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice).	• **Plot and display growth charts for patients 0-20 years, including BMI** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.	data. 3. Blood pressure, with the date of update for more than 50 percent of patients 2 years and older 4. Height for more than 50 percent of patients 2 years and older 5. Weight for more than 50 percent of patients 2 years and older 6. System calculates and displays BMI (NA for pediatric practices) 7. System plots and displays growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices)	percent. Stage 2 also requires plotting and displaying growth charts for patients 0-20 years instead of 2-20 years. Stage 2 omits head circumference for less than 2 years and BMI percentile is not included.
9. Record smoking status for patients 13 years old or older More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.(may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR	**5. Record smoking status for patients 13 years old or older.** More than 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	**PCMH 2B** 8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients	PCMH 2B is consistent with the stage 1 requirement. Stage 2 increases the requirement from more than 50 percent to more than 80 percent.

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
technology); excludes any EP who sees no patients 13 years or older.			
11. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule. Implement **one clinical decision** support rule.	**6. Use clinical decision support to improve performance on high-priority health condition.** • Implement **5 clinical decision** support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. • The EP, eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entre EHR reporting period.	**PCMH 3A** 1.The first important condition 2. The second important condition 3. The third condition, related to unhealthy behaviors or mental health or substance abuse. **PCMH 3E** 4. Performs patient-specific checks for drug-drug and drug-allergy interactions	PCMH 3A is consistent with the stage 1 requirement. Stage 2 requires 5 clinical decision support interventions while PCMH 3A requires 3. PCMH 3E is consistent with the stage 2 requirement.
2. Incorporate clinical lab-test results into EHR as structured data **More than 40 percent** of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.(may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology. Exception for an EP who orders no lab tests whose results are either in a positive/negative	**7. Incorporate clinical lab-test results into Certified EHR Technology as structured data.** **More than 55 percent** of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.	**PCMH 5A** 9. Electronically incorporates **at least 40 percent** of all clinical lab test results into structured fields in the medical record	PCMH 5A is consistent with the stage 1 requirement. Stage 2 increases the reporting requirement to **more than 55 percent** from **more than 40 percent.**

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
or numeric format during the HER reporting period).			
++[9]3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach Generate at least one report listing patients of the EP with a specific condition (may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology).	**8. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.** Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.	**PCMH 2D** 2. At least three different chronic or acute care services	PCMH 2D is consistent with the stage 1 and 2 requirements.
No corresponding stage 1 requirement.	**9. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.** **More than 10 percent** of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference.	**PCMH 2D** The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/ families and clinicians of services needed for: 1. At least three different preventive care services 2. At least three different chronic care services 3. Patients not recently seen by the practice	PCMH 2D is partially consistent with the stage 2 requirement. To be fully consistent, PCMH 2D needs to specify that **more than 10 percent** of all unique patients should receive reminders.

[9] Stage 1 menu requirement

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
++5. Provide patients with timely electronic access to health information (lab results, problem list, medication lists, allergies) within 4 business days of information being available to the EP **At least 10 percent** of patients are provided timely (available to the patient within four business days of being updated in the certified EHR) electronic access to their health information subject to the EP's discretion to withhold certain information. (Exclusion for an EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.	**10. Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.** • **More than 50 percent** of all unique patients seen by the EP during the EHR reporting period are provided timely (available within 24 hours of the encounter or within 3 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. • **More than 10 percent** of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view and are provided the capability to download their health information.	**PCMH 1C** 2. **At least 10 percent** of patients have electronic access to their current health information (including lab results, problem list, medication lists and allergies) within four business days of when the information is available to the practice	PCMH 1C is consistent with the stage 1 requirement. Stage 2 increases the reporting requirement to **more than 50 percent** from **at least 10 percent** and shortens the definition of timely to **24 hours of the encounter or 3 days it is available** from **4 days** it is available. Stage 2 also adds a new requirement: **more than 10 percent** of patients need to view and are provided the capability to download their health information.
13. Provide clinical summaries for patients for each office visit Clinical summaries provided to patients for **more than 50 percent** of all office visits **within 3 business days.**(may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology; Exclusion for any EP who has no office visits during the EHR reporting period).	**11. Provide clinical summaries for patients for each o ice visit.** Clinical summaries provided to patients **within 24 hours** for **more than 50 percent** of office visits.	**PCMH 1C** 3.Clinical summaries are provided to patients for **more than 50 percent** of office visits within **three business days**	PCMH 1C is consistent with the stage 1 requirement. Stage 2 accelerates the timeline for making information available from **3 business days** to **24 hours**.
++6. Use certified EHR to identify patient-specific education resources and provide if appropriate.	**12. Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient**	**PCMH 4A** 2.Uses an EHR to identify	PCMH 4A is consistent with the stage 1 and 2 requirements.

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.	Patient-specific education resources identified by Certified EHR Technology are provided to patients for **more than 10 percent** of all office visits by the EP. **More than 10 percent** of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.	patient-specific education resources and provide **to more than 10 percent** of patients, if appropriate	
No corresponding stage 1 requirement.	**13. Use secure electronic messaging to communicate with patients on relevant health information.** A secure message was sent using the electronic messaging function of Certified EHR Technology by **more than 10 percent** of unique patients seen during the EHR reporting period.	**PCMH 1C** The practice provides the following information and services to patients and families through a secure electronic system. 4. Two-way communication between patients/families and the practice	PCMH 1C is partially consistent with the stage 2 requirement. To be fully consistent, PCHM 1C needs to there is secure, two-way communication with more than **10 percent of patients.**
++7. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. Perform medication reconciliation for **more than 50 percent** of transitions of care in which the patient is transitioned into the care of the EP. (May be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology). Exclusion for an EP who was not the recipient of any transitions of care during the EHR reporting period.	**14. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.** The EP, eligible hospital or CAH performs medication reconciliation for **more than 65 percent** of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	**PCMH 3D** 1.Reviews and reconciles medications with patients/families for **more than 50 percent** of care transitions	PCMH 3D is consistent with the stage 1 requirement.. Stage 2 increases the reporting requirement from **more than 50 percent to more than 65 percent.**

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
++8. Provide summary care record for each transition of care and referral Provide summary of care record for **more than 50 percent** of transitions of care and referrals. (May calculate by reviewing only actions for patients with records maintained using certified EHR. Exclusion for EPs who neither transfer nor refer a patient to another provider during the EHR reporting period).	**15. The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.** • The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for **more than 65 percent** of transitions of care and referrals. • The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology **to a recipient with no organizational affiliation** and using a different Certified EHR Technology vendor than the sender for **more than 10 percent** of transitions of care and referral.	**PCMH 5C** On its own or in conjunction with an external organization, the practice systematically: 2. Demonstrates its process for sharing clinical information with admitting hospitals and emergency departments 5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization 7. Demonstrates the capability for electronic exchange of key clinical information with facilities 8. Provides an electronic summary-of-care record to another care facility for **more than 50 percent** of transitions of care	PCMH 5C is consistent with the stage 1 requirement. Stage 2 increases the reporting requirement to **more than 65 percent** from **more than 50 percent**. Stage 2 also adds a new requirement: transmitting a summary of care record with no organizational affiliation that uses a different Certified EHR Technology vendor for more than **10 percent** of transactions of care.

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
++9. Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. Performed **at least one test** of certified EHR 's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically. Exclusion for EPs who administers no immunizations or where no immunization registry has the capacity to receive the information electronically).	**16. Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.** Successful **ongoing submission** of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.	**PCMH 6F** 3.Data to immunization registries or systems	PCHM 6F is consistent with the stage 1 requirement. Stage 2 requires that PCMH 6F **specify the frequency** for submitting electronic data to immunization registries.
15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	**17. Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.** Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.	**PCMH 6G** 1.The practice uses an EHR system (or modules) that has been certified and issued a Certified HIT Products List (CHPL) Number(s) under the ONC (Office of the National Coordinator for Health Information Technology) HIT certification program	PCMH 6G is fully consistent with the stage 1 and 2 requirements.

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
		2.The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules) and implementing security updates as necessary and correcting identified security deficiencies	
3. Maintain an up-to date problem list of current and active diagnoses. More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	**No corresponding stage 2 requirement. Combined into Transition of Care.**	**PCMH 2B** 1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients	
5. Maintain active medication list More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	**No corresponding stage 2 requirement. Combined into Transition of Care.**	**PCMH 2B** 9. List of prescription medications with date of updates for more than 80 percent of patients	

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
6. Maintain active medication allergy list More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	**No corresponding stage 2 requirement. Combined into Transition of Care.**	**PCMH 2B** 2. Allergies, including medication allergies and adverse reactions* for more than 80 percent of patients	
Note: this requirement has been replaced by options for reporting clinical quality measures **10. Report ambulatory clinical quality measures to CMS** Successfully report to CMS (or, in the case of Medicaid EPs, the States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or in the case of Medicaid EPs, the States) (may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology)	**Clinical Quality Measures (CQM)** **Six domains** were specified: patient and family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources and clinical processes/ effectiveness with 125 potential measures. **Two options:** 1a. Select and submit 12 measures from the list of measures; one measure from each domain is required. If a provider's EHR doesn't include information for 12 measures, they must submit all of the measures they can. 1b. Report 11 "core" measures plus 1 "menu" measure 2. Submit and satisfactorily report CQM under the Physician Quality Reporting System's (PQRS) EHR Reporting Option (42 CFR 414.90	**PCMH 6F** 1. Ambulatory clinical quality measures to CMS	PCMH 6F is consistent with Stage 1 requirements. Stage 2 requirements specify options for submitting data.

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Core Meaningful Use +[5] Requirement

Meaningful Use Requirement Stage 1[6]	Meaningful Use Requirement Stage 2[7]	PCMH 2011	Analysis[8]
12. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days. (may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology; exclusion for any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period).	**Note: this requirement was eliminated and replaced by stage 2, objective 10.**	**PCMH 1C** 1. More than 50 percent of patients who request an electronic copy of their health information (e.g., problem lists, diagnoses, diagnostic test results, medication lists and allergies) receive it within three business days	
14. Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	**Note: this requirement was eliminated and replaced by stage 2, objective 15.**	**PCMH 5B** 6. Demonstrating capacity for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians	

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Menu Meaningful Use Requirements++[10]

Meaningful Use Requirement Stage 1	Meaningful Use Requirement Stage 2	PCMH 2011	Analysis
No corresponding stage 1 requirement.	**1. Imaging results and information are accessible through Certified EHR Technology.** **More than 40 percent** of all scans and tests whose result is an image ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology.	**PCMH 5A** The practice has a documented process for and demonstrates that it: 10. Electronically incorporates imaging test results into medical records.	To be fully consistent with the stage 2 requirement, PCMH 5A needs to require that more than 40 percent of imaging results are incorporated into medical records and are accessible through Certified EHR Technology.
No corresponding stage 1 requirement.	**2. Record patient family health history as structured data.** More than 29 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first degree relatives.		PCMH 2011 does not have a corresponding element.

[10] Stage 1 and 2 menu requirements

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10. Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. Performed **at least one test** of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive electronically).	**3. Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.** **Successful ongoing submission** of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire HER reporting period.	**PCMH 6F** 4. Syndromic surveillance data to public health agencies	PCMH 6F is consistent with the stage 1 requirement. To be fully consistent with the stage 2 requirement, PCMH 6F needs to specify the frequency of reporting syndromic surveillance data.
No corresponding stage 1 requirement.	**4. Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.** Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period.		PCMH 2011 does not have a corresponding element.
No corresponding stage 1 requirement.	**5. Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.** **Successful ongoing submission** of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.		PCMH 2011 does not have a corresponding element.
Implement drug formulary checks (drug-drug, drug-allergy remain on core) The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	**Note: this requirement was eliminated and incorporated into stage 2, Core measure 2.**	**PCMH 3E** 6. Alerts prescriber to formulary status	
2. Incorporate clinical lab-test results into EHR as	**Note: this requirement was eliminated and**	**PCMH 5A**	

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structured data More than 40 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.(may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology. Exception for an EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period)	**incorporated into stage 2, Core measure 1.**	9. Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in the medical record	
4. Send reminders to patients per patient preference for preventive/follow up care More than 20 percent of all patients 65 years or older or 5 years old or younger sent an appropriate reminder. (May calculate by reviewing only the actions for patients whose records are maintained using certified EHR technology) Exclusion for an EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR.	**Note: this requirement was eliminated and incorporated into stage 2, Core measure 8.**	**PCMH 2D** 1. At least three different preventive care services	

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Appendix C: NCQA Reports to PCMHs on Meaningful Use Status

2011 Patient-Centered Medical Home

Return to category results

CMS Meaningful Use Requirement:

(See Appendix 4 CMS Meaningful Use Summary Tables)

NOTE: The tables below indicate the ability of the practice to meet the Core and Menu Meaningful Use Requirements that are embedded in NCQA's PCMH 2011 standards, but do not guarantee that the practice will qualify for incentive payments through the Medicare and Medicaid EHR Incentive Program.

All Providers Must Meet..

- A core set of 15 requirements
- Five of 10 menu requirements
    - Five must include one of the following:
        - *The capability to submit electronic data to immunization registries/information systems, OR
        - *The capability to submit electronic syndromic surveillance data to public health agencies

Sample

Total Core Meaningful Use Requirements+ Met: 14
Total Menu Meaningful Use Requirements++ Met: 8

Core Meaningful Use Requirements+

Meaningful Use Requirement	Element	Factor	Factor Met	Requirement Met
Core Meaningful Use #1	**PCMH3E**	**3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list**	**Yes**	**Yes**
Core Meaningful Use #2	**PCMH3E**	**4. Performs patient-specific checks for drug-drug and drug-allergy interactions**	**Yes**	**Yes**
Core Meaningful Use #3	**PCMH2B**	**1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients**	**Yes**	**Yes**

Core Meaningful Use #4	PCMH3E	1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies	Yes	Yes
Core Meaningful Use #5	PCMH2B	9. List of prescription medications with the date of updates for more than 80 percent of patients	Yes	Yes
Core Meaningful Use #6	PCMH2B	2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients	Yes	Yes
Core Meaningful Use #7	PCMH2A	1. Date of birth	Yes	Yes
Core Meaningful Use #7	PCMH2A	2. Gender	Yes	
Core Meaningful Use #7	PCMH2A	3. Race	Yes	
Core Meaningful Use #7	PCMH2A	4. Ethnicity	Yes	
Core Meaningful Use #7	PCMH2A	5. Preferred language	Yes	
Core Meaningful Use #8	PCMH2B	3. Blood pressure, with the date of update for more than 50 percent of patients 2 years and older	Yes	Yes
Core Meaningful Use #8	PCMH2B	4. Height for more than 50 percent of patients 2 years and older	Yes	
Core Meaningful Use #8	PCMH2B	5. Weight for more than 50 percent of patients 2 years and older	Yes	
Core Meaningful Use #8	PCMH2B	6. System calculates and displays BMI (NA for pediatric practices)	Yes	
Core Meaningful Use #8	PCMH2B	7. System can plot and display growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices)	Yes	
Core Meaningful Use #9	PCMH2B	8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients (NA for pediatric practices if all patients <13 years)	Yes	Yes
Core Meaningful Use #10	PCMH6F	1. Ambulatory clinical quality measures to CMS or states	Yes	Yes
Core Meaningful Use #11	PCMH3A	1. The first important condition	Yes	Yes

Sample

Core Meaningful Use #12	PCMH1C	1. More than 50 percent of patients who request an electronic copy of their health information (including problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days	Yes	Yes
Core Meaningful Use #13	PCMH1C	3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days	Yes	Yes
Core Meaningful Use #14	PCMH5B	6. Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians	Yes	Yes
Core Meaningful Use #15	PCMH6G	1. The practice uses an EHR system (or modules) that has been certified and issued a Certified HIT Products List (CHPL) Number(s) under the ONC (Office of the National Coordinator for Health Information Technology) HIT certification program	No	No
Core Meaningful Use #15	PCMH6G	2. The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules) and implementing security updates as necessary and correcting identified security deficiencies	No	

Sample

Menu Meaningful Use Requirements++

Meaningful Use Requirement	Element	Factor	Factor Met	Requirement Met
Menu Meaningful Use #1	PCMH3E	6. Alerts prescribers to formulary status	Yes	Yes
Menu Meaningful Use #2	PCMH5A	9. Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in medical records	Yes	Yes
Menu Meaningful Use #3	PCMH2D	2. At least three different chronic care services	Yes	Yes
Menu Meaningful Use #4	PCMH2D	1. At least three different preventive care services	Yes	Yes
Menu Meaningful Use #5	PCMH1C	2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists, and allergies) within four business days of when the information is available to the practice	Yes	Yes
Menu Meaningful Use #6	PCMH4A	2. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate	No	No
Menu Meaningful	PCMH3D	1. Reviews and reconciles medications with patients/families for more than 50 percent of	No	No

Use #7		care transitions		
Menu Meaningful Use #8	PCMH5B	7. Providing an electronic summary of the care record to another provider for more than 50 percent of referrals.	Yes	Yes
Menu Meaningful Use #8	PCMH5C	8. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care.	Yes	
Menu Meaningful Use #9	PCMH6F	3. Data to immunization registries or systems	Yes	Yes
Menu Meaningful Use #10	PCMH6F	4. Syndromic surveillance data to public health agencies.	Yes	Yes

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Sample

Appendix D: Crosswalk of Proposed CQMs for EP's and NCQA Programs

NQF #	Measure	Steward	Stage 1	Physician HEDIS*	DRP**	HSRP***
0001	*Asthma: Assessment of Asthma Control*	AMA-PCPI	No			
0002	*Appropriate Testing for Children w/ Pharyngitis*	NCQA	Menu Set	Yes		
0004	*Initiation and Engagement of Alchol and Other Drug Dependence Treatment*	NCQA	Menu Set	Yes		
0014	*Prenatal Care: Anti-D Immune Globulin*	AMA-PCPI	Menu Set			
0012	*Prenatal Care: Screening for HIV*	AMA-PCPI	Menu Set			
0018	*Controlling High Blood Pressure*	NCQA	Menu Set	Yes		
0022	*Use of High Risk Medications in the Elderly*	NCQA	No	Yes		
0024	*Weight Assessment and Counseling for Nutrition and Physical Activity*	NCQA	Alternate Core	Yes		
0028	*Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*	AMA-PCPI	Core			Yes
0031	*Breast Cancer Screening*	NCQA	Menu Set	Yes		
0032	*Cervical Cancer Screening*	NCQA	Menu Set	Yes		
0033	*Chlamydia Screening in Women*	NCQA	Menu Set	Yes		
0034	*Colorectal Cancer Screening*	NCQA	No	Yes		
0036	*Use of Appropriate Medications for Asthma*	NCQA	Menu Set	Yes		
0038	*Childhood Immunization Status*	NCQA	Alternate Core	Yes		
0041	*Preventive Care and Screening: Influenza Immunization*	AMA-PCPI	Alternate Core			
0043	*Pneumonia Vaccination Status for Older Adults*	NCQA	Menu Set			
0045	*Osteoporosis: Communication with the Physician Managing Ongoing Care Post-Fracture*	NCQA	No			
0046	*Osteoporosis: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Old*	NCQA	No			
0047	*Asthma Pharmacologic Therapy for Persistent Asthma*	AMA-PCPI	Menu Set			
0048	*Osteoporosis: Management Follow Fracture of Hip, Spine or Distal Radium for Men and*	NCQA	No	Yes		
0050	*Osteoarthritis: Function and Pain Assessment*	AMA-PCPI	No			
0051	*Osteoarthritis: Assessment for use of Anti-Inflammatory OTC Medication*	AMA-PCPI	No			
0052	*Use of Imaging Studies for Low Back Pain*	NCQA	Menu Set	Yes		
0055	*Diabetes: Eye Exam*	NCQA	Menu Set	Yes	Yes	
0056	*Diabetes: Foot Exam*	NCQA	Menu Set	Yes	Yes	
0058	*Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis*	NCQA	No	Yes		
0059	*Diabetes: Hemoglobin A1c Poor Control*	NCQA	Menu Set	Yes	Yes	
0060	*Hemoglobin A1c test for Pediatric Patients*	NCQA	No			
0061	*Diabetes: Blood Pressure Management*	NCQA	Menu Set	Yes	Yes	
0062	*Diabetes: Urine Screening*	NCQA	Menu Set	Yes	Yes	
0064	*Diabetes: LDL Management*	NCQA	Menu Set	Yes	Yes	
0066	*CAD: ACE Inhibitor or ARB - Diabetes or LVEF*	AMA-PCPI	No			
0067	*CAD: Antiplatelet Therapy*	AMA-PCPI	Menu Set			
0068	*IVD: Use of Aspirin or Another Antithrombotic*	NCQA	Menu Set	Yes		Yes
0069	*Appropriate Treatment for Children with URI*	NCQA	No	Yes		
0070	*CAD: Beta-Blocker Therapy - Prior MI or LVEF*	AMA-PCPI	Menu Set			
0073	*IVD: Blood Pressure Management*	NCQA	Menu Set	Yes		Yes
0074	*CAD: Lipid Control*	AMA-PCPI	Menu Set			
0075	*IVD: Complete Lipid Panel & LDL Control*	NCQA	Menu Set	Yes		Yes

*MU Stage 2 Measures in Physician HEDIS

**MU Stage 2 Measures in Diabetes Recognition Program

***MU Stage 2 Measures in Heart Stroke Recognition Program

NQF #	Measure	Steward	Stage 1	Physician HEDIS*	DRP**	HSRP***
0081	*HF: ACE Inhibitor or ARB for LVSD*	AMA-PCPI	Menu Set			
0083	*HF: Beta-Blocker Therapy for LVSD*	AMA-PCPI	Menu Set			
0086	*POAG: Optic Nerve Evaluation*	AMA-PCPI	Menu Set			
0088	*Diabetic Retinopathy: Documentation Presence / Absence of Macular Edema*	AMA-PCPI	Menu Set			
0089	*Diabetic Retinopathy: Communication with the Physician*	AMA-PCPI	Menu Set			
0097	*Medication Reconciliation*	AMA-PCPI	No			
0098	*Urinary Incontinence: Assessment of Urinary Incontinence in Women 65 +*	NCQA	No			
0100	*Urinary Incontinence: Plan of Care*	AMA-PCPI	No			
0102	*COPD: Bronchodilator Therapy*	AMA-PCPI	No			
0103	*MDD: Diagnostic Evaluation*	AMA-PCPI	No			
0105	*Anti-depressant Medication Management*	NCQA	Menu Set	Yes		
0106	*Diagnosis of ADHD in PC for School Children and Adolescents*	ICSI	No			
0107	*Management of ADHD in Primary Care for School Children and Adolescents*	ICSI	No			
0108	*Follow Up for Children Prescribed ADHD Medication*	NCQA	No	Yes		
0110	*Bipolar Disorder and Major Depression: Appraisal for Substance Abuse*	CQAIMH	No			
0112	*Bipolar Disorder: Monitoring Change in level-of-functioning*	CQAIMH	No			
0239	*Perioperative Care: VTE Prophylaxis*	AMA-PCPI	No			
TBD	*Stroke and Stroke Rehab: CT or MRI Reports*	AMA-PCPI	No			
0271	*Perioperative Care: Discontinuation of Antibiotics*	AMA-PCPI	No			
0312	*Lower Back Pain: Repeat Imaging Studies*	NCQA	No	Yes		
0321	*Adult Kidney Disease: Peritoneal Dialysis Adequacy*	AMA-PCPI	No			
0322	*Back Pain: Initial Visit*	NCQA	No	Yes		
0323	*Adult Kidney Disease: Hemodialysis Adequacy*	AMA-PCPI	No			
0382	*Oncology: Radiation Dose Limits to Normal Tissues*	AMA-PCPI	No			
0383	*Oncology: Measure Pair - Medical and Radiation Plan of Care for Plan*	AMA-PCPI	No			
0384	*Oncology: Measure Pair - Medical and Radiation Pain Intensity Quantified*	AMA-PCPI	No			
0385	*Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients*	AMA-PCPI	Menu Set			
0387	*Breast Cancer: Hormonal Therapy for Stage IC-IIIC ER/PR Breast Cancer*	AMA-PCPI	Menu Set			
0388	*Prostate Cancer: 3D Radiotherapy*	AMA-PCPI	No			
0389	*Prostate Cancer: Adoidance of Overuse of Bone Scan*	AMA-PCPI	Menu Set			
0399	*Hepatitis C: Hep A Vaccination in Patients with HCV*	AMA-PCPI	No			
0400	*Hepatitis C: Hep B Vaccination in Patients with HCV*	AMA-PCPI	No			
0401	*Hepatitis C: Counseling Regarding Risk of Alcohol Consumption*	AMA-PCPI	No			
0403	*Medical Visits*	AMA-PCPI	No			
0405	*Pneumocystitis jiroveci pneumonia (PCP) Prophylaxis*	AMA-PCPI	No			
0406	*Patients with HIV/AIDS Prescribed Protent Antiretroviral Therpy*	AMA-PCPI	No			
0407	*HIV RNA Control After 6 Months Potent Anitretroviral Therpay*	NCQA	No			
0418	*Screening for Clinical Depression*	CMS	No			
0419	*Documentation of Current Medications in the Medical Record*	CMS	No			
0421	*Adult Weight Screening and Follow-Up*	CMS	Core			
0507	*Radiology: Stenosis Measurement in Carotid Imaging Studies*	AMA-PCPI	No			
0508	*Radiology: Inappropriate Use of ''Probably Benign'' Assessment*	AMA-PCPI	No			

*MU Stage 2 Measures in Physician HEDIS

**MU Stage 2 Measures in Diabetes Recognition Program

***MU Stage 2 Measures in Heart Stroke Recognition Program

NQF #	Measure	Steward	Stage 1	Physician HEDIS*	DRP**	HSRP***
0510	*Radiology: Exposure Time Reported for Procedures Using Fluoroscopy*	AMA-PCPI	No			
0513	*Thorax CT: Use of Contrast Material*	CMS	No			
0519	*Diabetic Foot Care and Patient/Caregiver Education*	CMS	No			
0561	*Melanoma: Coordination of Care*	AMA-PCPI	No			
0562	*Melanoma: Overutilization of Imaging Studies in Melanoma*	AMA-PCPI	No			
0564	*Cataracts: Complications within 30 Days Following Cataract Surgery*	AMA-PCPI	No			
0565	*Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Surgery*	AMA-PCPI	No			
0575	*Diabetes: Hemoglobin A1c Control (<8%)*	NCQA	Menu Set	Yes		
0608	*Pregnant Women that had HBsAg Testing*	Ingenix	No			
0710	*Depression Remission at Twelve Months*	MNCM	No			
0711	*Depression Remission at Six Months*	MNCM	No			
0712	*Depression Utilization of the PHQ–9 Tool*	MNCM	No			
1335	*Children with Dental Decay or Cavities*	HRSA	No			
1365	*Adolescent Major Depressive Disorder: Suicide Risk Assessment*	AMA-PCPI	No			
1401	*Maternal Depression Screening*	NCQA	No			
1419	*Prevention Intervention as Part of Well/Ill Child Care*	rsity of Minr	No			
1525	*Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation*	AMA-PCPI	No			
TBD	*Cholesterol—Fasting Low LCL Test and Risk-Stratified Testing*	CMS	No			
TBD	*Falls: Risk Assessment for Falls*	AMA-PCPI	No			
TBD	*Falls: Plan of Care for Falls*	AMA-PCPI	No			
TBD	*Adult Kidney Disease: Blood Pressure Management*	AMA-PCPI	No			
TBD	*Adult Kidney Disease: Patients on Erythropoiesis Stimulating Agent*	AMA-PCPI	No			
TBD	*Chronic Wound Care: Use of Wet to Dry Dressings*	AMA-PCPI	No			
TBD	*Dementia: Staging of Dementia*	AMA-PCPI	No			
TBD	*Dementia: Cognitive Assessment*	AMA-PCPI	No			
TBD	*Dementia: Functional Status Assessment*	AMA-PCPI	No			
TBD	*Dementia: Counseling Regarding Safety Concerns*	AMA-PCPI	No			
TBD	*Dementia: Counseling Regarding Risks of Driving*	AMA-PCPI	No			
TBD	*Dementia: Caregiver Education and Support*	AMA-PCPI	No			
TBD	*Chronic Wound Care: Patient education re: long term compression therapy*	AMA-PCPI	No			
TBD	*Rheumatoid Arthritis (RA): Functional Status Assessment*	AMA-PCPI	No			
TBD	*Glaucoma Screening in Older Adults*	NCQA	No	Yes		
TBD	*Chronic Wound Care: Patient Education Regarding Diabetic Foot Care*	AMA-PCPI	No			
TBD	*Hypertension: Improvement in Blood Pressure*	CMS	No			
TBD	*Closing the Referral Loop: Receipt of Specialist Report*	CMS	No			
TBD	*Functional Status Assessment for Knee Replacement*	CMS	No			
TBD	*Functional Status Assessment for Hip Replacement*	CMS	No			
TBD	*Functional Status Assessment for Complex Chronic Conditions*	CMS	No			
TBD	*ADE Prevention: Outpatient Therapeutic Drug Monitoring*	CMS	No			
TBD	*Screening for High Blood Pressure*	CMS	No			
TBD	*Hypertension: Blood Pressure Management*	AMA-PCPI	No			

*MU Stage 2 Measures in Physician HEDIS
**MU Stage 2 Measures in Diabetes Recognition Program
***MU Stage 2 Measures in Heart Stroke Recognition Program